OLR RESEARCH REPORT

November 29, 2012 2012-R-0510

OLR BACKGROUNDER: PATIENT ACCESS TO MEDICAL RECORDS

By: Nicole Dube, Associate Analyst

This report updates OLR Report 2010-R-0339, which summarizes state laws on patient access to medical records in a question and answer format. (The terms "medical records" and "health records" are used interchangeably reflecting their usage in statute.)

PATIENT ACCESS TO MEDICAL RECORDS FROM INDIVIDUAL HEALTH CARE PROVIDERS

Do Patients Have Access to Their Medical Records?

The answer is yes. State law requires health care providers, with limited exceptions, to give patients who ask, complete and current information they have about their patients' diagnosis, treatment, and prognosis. Providers must also notify patients of any test results they possess or request for purposes of diagnosis, treatment, or prognosis (CGS § 20-7c(b)).

A patient may obtain copies of his or her medical records by asking the provider in writing. The patient's attorney or authorized representative can also make such a request. Such records include bills, x-rays, copies of lab report results, prescriptions, contact lens specifications under certain conditions, and other technical information used to assess the patient's health condition. The provider must supply the health record within 30 days of the request (CGS § 20-7c(d)).

Sandra Norman-Eady, Director
Phone (860) 240-8400
FAX (860) 240-8881
http://www.cga.ct.gov/olr

Connecticut General Assembly
Office of Legislative Research

Room 5300
Legislative Office Building
Hartford, CT 06106-1591
Olr@cga.ct.gov

When Can a Health Care Provider Withhold This Information?

By law, a health care provider can withhold medical information from a patient if he or she reasonably determines that the information would be detrimental to the patient's physical or mental health or would likely cause the patient to harm him- or herself or someone else. In this case, the provider can supply the information to an appropriate third party or another provider who can release it to the patient. A patient aggrieved by a provider's decision to withhold information can, within 30 days of the decision, petition the Superior Court for a disclosure order (CGS § 20-7c(e)).

Is There a Cost to Obtain Medical Records?

A health care provider can charge up to 65 cents per page, including any applicable research or handling fees, related costs, and first class postage to supply a patient's health record. The provider can also charge a patient the amount necessary to cover the cost of material for providing a copy of an x-ray. A provider cannot impose these charges if the patient documents that the records are necessary to support a Social Security claim or appeal.

A provider cannot refuse to return to a patient, original or copied medical records from another provider. When returning these records, the provider may keep copies for the patient's file as long as the provider does not charge the patient for the copying costs (CGS § 20-7c(d))..

Can Laboratory Test Results be Reported Directly to a Patient?

State law generally does not allow the direct reporting of laboratory test results to patients. But, they may be reported to patients upon the written request of the provider who ordered the testing (Conn. Agencies Reg., § 19a-36-D32). If a provider asks the patient to undergo repeated testing at regular intervals over a specified time period, the provider can issue a single authorization allowing a laboratory to give all the test results directly to the patient. The testing must be to determine a diagnosis, prognosis, or recommended treatment course (CGS § 20-7c(c)).

Generally, this prohibition is designed to protect the patient by insuring proper explanation and interpretation of laboratory findings, and avoiding possible harmful misinterpretations.

Does the Law on Patient Access to Medical Records Apply to Mental Health Conditions?

The law specifies that its provisions on patient access to medical records (CGS § 20-7c(a)-(h)) do not apply to any information related to psychiatric or psychological problems or conditions (CGS § 20-7c(f)).

To Which Health Care Providers Do the Above Provisions Apply?

The law applies to people licensed or certified to provide the following health care services: medicine and surgery, chiropractic, naturopathy, athletic training, physical therapy, occupational therapy, substance abuse counseling, radiography, midwifery, nursing, dentistry, dental hygiene, optometry, optics, respiratory care, perfusion, pharmacy, psychology, marital and family therapy, clinical social work, professional counseling, veterinary medicine, massage therapy, electrology, hearing instruments, speech pathology and audiology, and emergency medical services (CGS § 20-7b).

Can a Patient's Medical Records be Released to Another Provider?

If a patient asks in writing, a provider must furnish a copy of the patient's health record to another provider. This includes x-rays, copies of lab reports, prescriptions, and other technical information used to assess the patient's condition. The written request must specify the receiving provider's name. The patient is responsible for the reasonable costs of providing the information (CGS § 20-7d).

In addition, if a patient or provider who orders medical tests for the patient requests it, a clinical laboratory must supply the test results to any other provider seeing the patient for treatment, diagnosis, or prognosis purposes (CGS § 20-7c(b)).

PATIENT ACCESS TO RECORDS FROM HOSPITALS AND OTHER HEALTH CARE INSTITUTIONS

Can a Person Access His or Her Hospital Records?

The answer is yes. By law, health care institutions, which include hospitals, must provide a copy of a patient's health record upon the written request of the patient or his or her attorney or authorized representative. The health record includes copies of bills, lab reports, prescriptions, and other technical information used in assessing the patient's condition (CGS § 19a-490b(a)).

The institution must also give the patient or his or her designated health care provider a reasonable opportunity to examine retained tissue slides and pathology tissue blocks. If the patient or the patient's attorney or designated provider asks in writing, the institution must send the original retained tissue slide or tissue block directly to the patient's designated physician, lab, or institution (CGS § 19a-490b(a)).

In addition, the law requires public or private hospitals receiving state aid to allow discharged patients or their physician or attorney to examine their hospital record, at the patient's request. This record includes the history, bedside notes, charts, pictures, and plates kept concerning the treatment. The patient or the patient's physician or attorney must be allowed to make copies of this information (CGS § 4-104).

Can a Health Care Institution Charge for Health Records?

Like an individual health care provider, a health care institution can charge up to 65 cents per page, including any applicable research or handling fees, related costs, and first class postage to supply a patient's health record. The institution can also charge the amount necessary to cover the costs of material for (1) providing a copy of an x-ray or (2) furnishing an original retained slide or tissue block or a new section cut from a retained tissue block. Such charges cannot be imposed if the health record is necessary for a documented Social Security claim or appeal (CGS § 19a-490b(a)).

An institution must provide the requested health record within 30 days of the request, unless the patient's request was received less than 30 days from his or her discharge. In that case, the institution must provide the record when it is completed (CGS § 19a-490b(b)).

In addition, an institution cannot deny a health record request because of a patient's inability to pay the required fees if the patient provides an affidavit attesting so (CGS § 19a-490b(d)).

MEDICAL RECORDS RETENTION BY INDIVIDUAL HEALTH CARE PROVIDERS

How Long Must a Health Care Provider Keep a Patient's Medical Records?

Generally, a health care provider must retain a patient's medical records for seven years after the last treatment date, or three years after the patient's death.

Providers must also retain the following:

1. Lab and phenylketonuria (PKU) reports for five years;

2. X-ray film for three years; and

3. pathology slides, electroencephalograms (EEGs), and electrocardiograms (ECGs) for seven years, except that if subsequent ECGs are performed the provider may discard previous tests if the results are unchanged (Conn. Agencies Reg., § 19a-14-42).

What Happens When a Health Care Provider Dies or Retires?

A health care provider who terminates a practice (or his or her executor or responsible relative in the case of death) must inform patients by (1) notice published in a local newspaper and (2) a letter sent to each patient seen within the past three years before the date the practice was discontinued. Patient medical records must be kept for 60 days after the notice (Conn. Agencies Reg., § 19a-14-44).

A provider who purchases or otherwise assumes a retiring or deceased provider's practice cannot refuse to return original or copied medical records to a patient who decides not to continue receiving care from that practice. The successor provider cannot charge the patient for the cost of copying the records of the retired or deceased provider (CGS § 20-7c(d)).

What Happens When a Health Care Provider Abandons His or Her Practice?

If a health care provider abandons his or her practice, the Department of Public Health (DPH) commissioner may appoint a licensed health care provider to keep the abandoned provider's records and disburse them to patients upon their request (CGS § 20-7c(g)).

What if a Patient Changes Health Care Providers?

If a patient changes health care providers and asks the provider to transfer the records to the new provider, the first provider is not required to retain the records (Conn. Agencies Reg., § 19a-14-43).

MEDICAL RECORDS RETENTION BY HEALTH CARE INSTITUTIONS

How Long Must a Hospital Retain Patient Medical Records?

Medical records must be filed in an accessible manner in the hospital and kept a minimum of 10 years after a patient's discharge. Original records can be destroyed sooner if they are preserved by a process consistent with current hospital industry standards (Conn. Agencies Reg., § 19a-13-D3(d)(6).

How Long Must a Nursing Home Retain Patient Medical Records?

Nursing homes must preserve all medical records, in paper or electronic format, for at least seven years after a patient's (1) death at the facility or (2) discharge from the facility. Nursing homes can maintain all or part of these records electronically in a format that complies with accepted professional standards (CGS § 19a-522b).

What Happens to Patient Health Records if a Health Care Institution Closes?

When a health care institution closes and relinquishes its license to DPH, it must provide the department with a certified document specifying where its patient health records will be stored and the procedure for patients, former patients, or their authorized representatives to access the records. This certified document must also include provision (1) concerning storage if the storage location closes or changes ownership and (2) granting DPH authority to enforce the document's provisions if the storage location closes or changes ownership. The law imposes a civil penalty of up to $100 for each day the institution fails to comply with the terms of the certified document (CGS § 19a-490b(e)).

ELECTRONIC MEDICAL RECORDS

Are Health Care Providers and Institutions Required to Keep Electronic Medical Records?

The law allows licensed health care institutions to create, maintain, or use medical records or medical record systems in electronic format, paper, or both if the system can store medical records and patient health care information in a reproducible and secure manner. It also allows health care providers with prescriptive authority to use electronic prescribing systems (CGS §§ 19a-25b and 19a-25c).

ND:ts